catheterization. I will briefly illustrate how cardiac catheterization can help in the differential diagnosis between constrictive pericardial disease and cardiomyopathy. In general, with constrictive disease there is a plateau of pressure: the pulmonary wedge pressure, the diastolic pressure in the pulmonary artery, the diastolic pressure in the right ventricle and the mean right atrial pressure will all be the same. In cardiomyopathy, even though the right atrial pressure may be elevated and to a degree higher than illustrated in Figure 9, the left sided pressures are much higher. This discrepancy between left and right filling pressures is a strong point favoring cardiomyopathy over constriction. There may be a rare instance in which it is impossible by all of these techniques to differentiate constrictive pericardial disease from restrictive myocardial disease, and in this situation I feel that an exploratory thoracotomy is advisable for the obvious reason that constrictive pericarditis is a potentially curable disease.

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Prophylaxis in Meningococcus Carriers

There is a certain amount of controversy over the problem of the management of a family from which there has been a child admitted to the hospital with acute meningococcic infection in the form of meningococcemia or meningococcus meningitis. What does one do about the remainder of the family who have been exposed to the carrier responsible for the infection in the child? In the years when the meningococcus was very sensitive to sulfa drugs, the situation was an ideal one, since sulfa was very effective in treating the acute invasive infection from the meningococcus. At the same time it was extremely effective in ridding the carrier of the organism. Once resistance began to develop, however, sulfa drugs failed in both respects and the next drug used was penicillin, to which almost all strains are sensitive. Unfortunately, penicillin—though it is very effective in treating the acute severe infection with meningococcus—has very little effectiveness in clearing the carrier state. Investigators have turned to such drugs as rifampin (Rifadin®, Rimactane®) and minocycline (Minocin®) and in fact to the combination of these two antibiotics, so that these drugs do not seem to be the answer to the need to clear the carrier of the organism. My own feeling is that the best thing to do is to give no drugs to the close family contacts of a patient with meningococcemia or meningococcic meningitis, but to watch all of the persons who have been exposed to a carrier and obtain temperatures twice a day. In the event that a family member develops a fever without any explanation, it would seem indicated to treat such a child or adult exposed to meningococcus with large doses of penicillin given by mouth . . . It is quite clear that the occurrence of secondary cases within the family will be within the first week following the diagnosis of the infection in the primary case. So the worry about prevention involves primarily the first week after exposure, and it is during this week that the temperature taken twice daily could be very effective in turning up patients exposed to carriers who are coming down with an acute infection.

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